GOVERNMENT OF THE U.S. VIRGIN ISLANDS
DEPARTMENT OF PLANNING & NATURAL RESOURCES
DIVISION OF ENVIRONMENTAL PROTECTION
(340) 773-1082 / 774-3320

DPNR use only: Payment Type _____ Check _____Cash
Date Received_____   Receipt No._____
Permit No._____   Date Issued_____

Application for Infectious Medical Waste Transporter Registration

Infectious medical waste transporters must be permitted by DPNR. The initial permit is $55.00 (vehicle). Each additional vehicle is $10.00. Permits expire on March 31st of each year. The permit fee for the renewal applications received by April 1st is $55.00 (one vehicle). Each additional vehicle is $10.00. The permit fee for renewal applications received after April 1st is $75.00. Each additional vehicle is $10.00. Please submit the completed form to DPNR-DEP.

1. Application for (choose one): _____ New   _____Renewal
    (Applicant must be a legal entity, i.e.: Individual, partnership, corporation, association, or public body)

2. Facility Name: _____

3. Facility Address:_____
                                        Street   City   State   Zip Code

4. Contact Person: _____Telephone____(____)_____

5. Name of Facility Owner: _____

6. Mailing Address of Facility Owner:_____

7. Business Phone: ___(____)_____

8. 24 Hour Emergency Phone: __(___)_____

9. Name of Property Owner: _____

10. Mailing Address of Property Owner:_____
                                        Street   City   State   Zip Code

11. FEDERAL employer Identification Number of transporter: _____

12. Anticipated districts to be served:
    _____
    _____

13. List all known facilities where you will be taking infectious medical waste or further storage (attach additional sheets if necessary):

STORAGE	TREATMENT

14. Number of transport vehicles to be used:_____

15. Please submit the following information for each transport vehicle you wish to register (attach additional sheets, if necessary):

YEAR	MAKE	MODEL	TAG NUMBER	VEHICLE IDENTIFICATION NUMBER

16. For renewals only: Please attach copy of Manifest for Infectious Medical Waste transported in the last year.

17. CERTIFICATION:

I certify that, to the best of my knowledge and belief, the information provided in this application is true and accurate.

_____   _____   _____
Signature of Authorized Representative   Name of Authorized Representative (print or Type)   Date